MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

## Medical Services • Obstetrics

**December 2006 • Bulletin 389**

**Contents**



### Federal Deficit Reduction Act of 2005 Requirements Implemented

Effective January 1, 2007, all new provider applicants and all providers subject to re-enrollment processing will be required to certify that they comply with Section 1902(a) of the Social Security Act.

On February 8, 2005, President Bush signed into law the Deficit Reduction Act (DRA), which requires specified changes to Medicaid (Medi-Cal in California) law. One of those changes is the requirement for employee education about false claims recovery. These changes go into effect on January 1, 2007.

This article contains information about both the state and federal law regarding this new requirement. This article also serves as the official notice of new federal requirements for Medi-Cal providers in California.

**Federal Law**

Section 6032 of the DRA requires any entities that receive or make annual payments under the State Plan (Medi-Cal in California) of at least $5 million, as a condition of receiving such payments, to have established written policies and procedures about the Federal and State False Claims Act for their employees, agents and contractors.

Specifically, Section 6032 amends the Social Security Act, Title 42, United States Code, Section 1396a(a), by inserting an additional relevant paragraph, (68). To summarize, this new paragraph mandates that any entity that receives or makes payments under the State Plan of at least $5 million annually, as a condition of receiving such payments, must comply with the following requirements:

1. Establish written policies for all employees of the entity, including management and any contractor(s) or agent(s) of the entity. These written policies shall provide detailed information about the following:
   - Federal False Claims Act, including administrative remedies for false claims and statements established under Title 31, USC, Chapter 38.
   - State laws pertaining to civil or criminal penalties for false claims and statements; whistleblower protections under such laws; and the role of these laws in preventing and detecting fraud, waste and abuse in Federal health care programs.
2. The written policies must include details about the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

   Any employee handbook for the entity must include specific discussion of the laws about false claims and statements; the rights of employees to be protected as whistleblowers; and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

## 2007 CPT-4/HCPCS Code Update Reminder

The 2007 updates to *Current Procedural Terminology – 4th Edition* (CPT-4) codes and *Healthcare Common Procedure Coding System* (HCPCS) Level II codes become effective for Medicare on January 1, 2007. The Medi-Cal program has not yet adopted the 2007 updates. Providers must not use the 2007 codes to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

## Modifications to Selected HCPCS Update Policies

Effective for dates of service on or after January 1, 2007, selected policies related to the 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) are modified.

**Documentation Requirements for Retisert™**
When submitting *Treatment Authorization Requests* (TARs) for HCPCS code C9225 (fluocinolone acetonide intravitreal implant [Retisert™]), the following must be included:

- Documentation that the patient has chronic non-infectious uveitis affecting the posterior segment of the eye
- Documentation identifying the types of conventional treatment used and explanation as to why the treatment did not work, such as non-responsiveness, intolerability, etc.
- One of the following ICD-9 diagnosis codes:
  - 363.00 – 363.08 (focal chorioretinitis and focal retinochoroiditis)
  - 363.10 – 363.15 (disseminated chorioretinitis and disseminated retinochoroiditis)
  - 363.20 (chorioretinitis, unspecified)

**Cutback Policy for Initial Inpatient Consultation Services**
Reimbursement for initial inpatient consultation services (CPT-4 codes 99251 – 99255) is limited to once per month. Due to the recent deletion of CPT-4 codes 99261 – 99263, second and subsequent claims billed for the same month will be cut back as follows:

| Billed Code | Cutback Code |
|---|---|
| 99251 | 99231 |
| 99252 | 99231 |
| 99253 | 99232 |
| 99254 | 99232 |
| 99255 | 99232 |

*This information is reflected on manual replacement pages eval 7 (Part 2).*

### Cyanocobalamin Reimbursement Policy Update

Effective for dates of service on or after January 1, 2007, CPT-4 code 82607 (cyanocobalamin [vitamin B-12]) is reimbursable only when billed in conjunction with one or more of the following ICD-9 codes. Reimbursement continues to be restricted to three tests per year for the same recipient by the same provider, unless medical justification is entered in the *Remarks* area/*Reserved for Local Use* field (Box 19) of the claim or submitted as an attachment.

| ICD-9 Code | Description |
|---|---|
| 123.4 | Diphyllobothriasis, intestinal |
| 151.0 – 151.9 | Malignant neoplasm of stomach |
| 266.2 | Other B-complex deficiencies |
| 281.0 | Pernicious anemia |
| 281.1 | Other vitamin B-12 deficiency anemia |
| 281.3 | Other specified megaloblastic anemias not elsewhere classified |
| 281.9 | Unspecified deficiency anemia |
| 289.8 | Other specified diseases of blood and blood-forming organs |
| 290.0 – 290.9 | Dementias |
| 294.1 | Dementia in conditions classified elsewhere |
| 294.8 | Other persistent mental disorders due to conditions classified elsewhere |
| 294.9 | Unspecified persistent mental disorders due to conditions classified elsewhere |
| 310.0 | Frontal lobe syndrome |
| 356.9 | Hereditary and idiopathic peripheral neuropathy; unspecified |
| 357.4 | Polyneuropathy in other diseases classified elsewhere |
| 529.6 | Glossodynia |
| 535.10 – 535.11 | Atrophic gastritis without mention of hemorrhage; Atrophic gastritis with hemorrhage |
| 555.0 – 555.9 | Regional enteritis |
| 564.2 | Postgastric surgery syndromes |
| 577.1 | Chronic pancreatitis |
| 579.0 – 579.9 | Intestinal malabsorption |
| 751.1 | Atresia and stenosis of small intestine |
| 780.7 | Malaise and fatigue |
| 782.0 | Disturbance of skin sensation |
| V44.2 | Ileostomy |
| V44.4 | Other artificial opening of gastrointestinal tract |
| V45.3 | Intestinal bypass or anastomosis status |
| V45.89 | Other |

*This information is reflected on manual replacement page path chem 3 and 4 (Part 2).*

### Corrections: Hepatitis A Vaccine Codes

An article in the June 2006 *Medi-Cal Update* announced that effective for dates of service on or after July 1, 2006, CPT-4 code 90634 (Hepatitis A Vaccine [pediatric/adolescent], three dose) became a non-benefit. (This regimen is no longer in use.) However, several references to the code were inadvertently left in the provider manual. Those references have been removed.

In addition, the article announced removal of the SK (high risk) modifier requirement when billing CPT-4 code 90633 (Hepatitis A Vaccine [pediatric/adolescent], two dose). However, the *Modifiers Used With Procedure Codes* manual section was not updated to reflect that change. That section is now updated.

*These corrections are reflected on manual replacement pages inject 2 (Part 2), inject vacc 1 (Part 2), modif used 4 (Part 2) and non ph 11 (Part 2).*

### Increased Access to Plan B®

Effective for dates of service on or after January 1, 2007, physicians, non-physician medical practitioners and clinics may bill and be reimbursed for HCPCS code X7722, Plan B® (levonorgestrel, 0.75 mg). A maximum of two packs may be reimbursed per recipient, per month, any provider and six packs per recipient, per year, any provider.

Plan B® is an emergency contraceptive (morning after pill) that was approved by the Food and Drug Administration in July 1999. Plan B® contains two progestin-only pills containing levonorgestrel 0.75 mg; it is a single course of treatment to be taken within 3 days (72 hours) of unprotected sex and can reduce the risk of pregnancy by 89% after unprotected sex or a contraceptive accident, such as a condom breaking.

*This information is reflected on manual replacement page fam planning 8 (Part 2).*

### Laboratory Chemistry Procedures Update

Effective for dates of service on or after January 1, 2007, the California Department of Health Services (CDHS) is updating the maximum reimbursement amounts for laboratory chemistry procedures. These rates are as follows:

| Description | Rate |
|---|---|
| 1 – 2 clinical chemistry tests | $ 5.82 |
| 3 clinical chemistry tests | 7.43 |
| 4 clinical chemistry tests | 7.84 |
| 5 clinical chemistry tests | 8.74 |
| 6 clinical chemistry tests | 8.77 |
| 7 clinical chemistry tests | 9.14 |
| 8 clinical chemistry tests | 9.46 |
| 9 – 10 clinical chemistry tests | 9.70 |
| 11 clinical chemistry tests | 9.87 |
| 12 clinical chemistry tests | 10.10 |
| 13 – 16 clinical chemistry tests | 11.82 |
| 17 – 18 clinical chemistry tests | 11.90 |
| 19 clinical chemistry tests | 12.36 |
| 20 clinical chemistry tests | 12.76 |
| 21 clinical chemistry tests | 13.16 |
| 22 clinical chemistry tests | 13.56 |

*Please see* **Laboratory Update**, *page 5*

To comply with *Welfare and Institutions Code*, Section 14105.22, the Medi-Cal maximum reimbursement rates for clinical laboratory or laboratory procedures must be no higher than 80 percent of the average of the Medicare rates allowed by National Heritage Insurance Company (NHIC)-North and NHIC-South.

Information about individual laboratory procedure reimbursement rates for the CPT-4 code 80000 series and HCPCS codes S3620 and S3820 can be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "Medi-Cal Rates" under the "Provider Reference" heading.

*This information is reflected on manual replacement pages path organ 2 (Part 2) and rates max lab 1 (Part 2).*

## Radiopharmaceutical Policy and Rate Changes

**Discontinued Medi-Cal Benefit**
Effective December 1, 2006, HCPCS code A9555 (rubidium Rb-82, diagnostic, per study dose) is no longer a Medi-Cal benefit because it is used in conjunction with CPT-4 codes 78491 (myocardial imaging, positron emission tomography [PET], perfusion; single study at rest or stress) and 78492 (myocardial imaging, positron emission tomography [PET], perfusion; multiple studies at rest and/or stress), which are not Medi-Cal benefits.

**Rate Changes**
The following radiopharmaceutical codes have rate changes: A9502, A9521, A9547, A9551, A9552 and A9600. Providers can access the adjusted rates for these codes from the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "Medi-Cal Rates" under the "Provider Reference" section.

**TAR Requirement**
Effective January 1, 2007, code A9545 (iodine I-131 tositumomab, therapeutic, per treatment dose) requires a *Treatment Authorization Request* (TAR).

*This information is reflected on manual replacement pages hcpcs ii 2 (Part 2), inject list 16 (Part 2) and radi dia 19 (Part 2).*

## Oxygen and Related Equipment Policy: December Update

*Most of the following article ran in the November Medi-Cal Update. Some updates, in underlined or struckout text, have been added to reflect new policy or rate information.*

Legislation was signed July 12, 2006, amending *Welfare and Institutions Code*, Section 14105.48, specifying that effective for dates of service on or after January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes.

Therefore, effective for dates of service on or after January 1, 2007, the following coverage and reimbursement policy changes will be implemented.

**Billing Guidelines**
A chart has been inserted in the *Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment* section to show HCPCS oxygen and equipment codes that are:

- Reimbursable for the same date of service
- Not reimbursable in the same month as an initial purchase or rental

**TAR Requirement**
All requests for oxygen delivery systems, oxygen contents and related equipment will require a *Treatment Authorization Request* (TAR), which must be sent to the Fresno Medi-Cal Field Office. Authorization for oxygen therapy will be granted for the lowest cost delivery system that best meets the recipient's medical needs. Providers may need to request corrections to currently authorized TARs or submit new TARs for dates of service on or after January 1, 2007.

*Please see* **Oxygen and Related Equipment**, *page 6*

**Reimbursement**
Reimbursement rates for oxygen therapy services will be the lesser of the amount billed or 80 percent of the lowest maximum allowance of the California Medicare reimbursement rate for the same or similar item or service. Rates will be adjusted for the following HCPCS codes: A4615, A4620, E0424, E0425, E0430, E0441, E0442, E1353 and E1355.

**Procedure Codes**
The following HCPCS Level II oxygen delivery systems and oxygen contents procedure codes will be new benefits covered by Medi-Cal: E0439, E0440, E0443, E0444 and E1392*****.

* This code was activated with the 2006 HCPCS annual update effective for dates of service on or after November 1, 2006.

The descriptors for the following currently covered HCPCS Level II oxygen delivery system and oxygen contents procedure codes will be revised from local descriptors to national descriptors. Policy will be revised accordingly: E0424, E0441 and E0442.

All other currently covered benefits will remain in effect.

**'One Unit of Oxygen' Redefined**
One unit of oxygen equals "one month's supply," regardless of how many pounds or cubic feet of oxygen are supplied. This change in the definition of "one unit of oxygen" affects codes E0441, E0442, E0443 and E0444.

**Modifiers**
The following three new HCPCS Level II modifiers are to be used only with rental of stationary gaseous (E0424) or liquid (E0439) systems or with rental of a non-portable oxygen concentrator (E1390, E1391). These modifiers are not reimbursable with any other codes.

QE Prescribed amount of oxygen is less than one liter per minute (LPM). The reimbursement amount is reduced by 50 percent.

QF Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is also prescribed. The reimbursement amount is increased by 50 percent.

QG Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is not prescribed. The reimbursement amount is increased by 50 percent.

**Note:** The rental rates for E0424, E0439, E1390 and E1391 will vary when billed with modifier QE, QF, QG or RR depending on the prescribed oxygen flow. For oxygen flow rates equal to or greater than one and equal to or less than four liters per minute, modifier RR is to be used as a single modifier. For claims submitted with modifier QE, QF or QG, it is not necessary to include modifier RR.

**Criteria**
Medi-Cal covers oxygen therapy for recipients who meet the established medical criteria. The requirements for establishing the medical necessity for oxygen are listed below.

A. *Laboratory evidence* of hypoxemia in the chronic stable state or exercise induced hypoxemia **and a prescription** from the recipient's physician specifying all of the following information must be submitted with the request for prior authorization:

1. The diagnosis or medical condition requiring supplemental oxygen
2. The oxygen flow rate requested
3. An estimate of the frequency (hours per day) and duration of use (months)

A prescription for "Oxygen prn" or "Oxygen as needed" is unacceptable.

*Please see* **Oxygen and Related Equipment**, *page 7*

*Initial requests* for oxygen must include a recent arterial blood gas (ABG) report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

*Supplemental oxygen* requests require that the recipient's arterial partial pressure of oxygen ($Pa_{02}$) must be 55 mm Hg or less, or the oxygen saturation ($Sa_{02}$) must be 88 percent or less with the test taken on room air in the chronic stable state and, if hospitalized, no more than two days prior to hospital discharge.

If the arterial $Pa_{02}$ is 56 – 59 mm Hg or the $Sa_{02}$ is 89 percent, a secondary diagnosis is necessary, such as but not limited to: congestive heart failure, cor pulmonale or erythrocytosis/erythrocythemia. Medi-Cal field office consultants who are reviewing the medical necessity for supplemental oxygen use will take into consideration that the laboratory specified values above may vary due to factors such as a recipient's age, or the altitude level at which the test was taken.

If the arterial $Pa_{02}$ is equal to or greater than 60 mm Hg or the $Sa_{02}$ is equal to or greater than 90 percent, the medical necessity for oxygen is unlikely to be established. However, individual cases submitted with detailed documentation substantiating medical necessity will be evaluated on a case-by-case basis.

For pediatric recipients an oximetry study with $Sa_{02}$ submitted with the TAR is satisfactory. No ABG is required. Requests for supplemental oxygen for pediatric recipients with a $Sa_{02}$ of 90 mm Hg or greater will be considered on a case-by-case basis. Requests for supplemental oxygen for children with medical conditions covered by California Children's Services (CCS) should be submitted to the appropriate CCS county office for approval.

B. A stationary oxygen system will be authorized unless the recipient's need to pursue usual activities with a portable oxygen system is established with the submitted documentation.

C. If the recipient's clinical condition or need for supplemental oxygen changes, the attending physician must update the medical documentation and laboratory evidence accordingly, and the oxygen and related equipment provider must submit the new data with a new TAR.

D. If the supplemental oxygen system requested is not the lowest cost system that will meet the recipient's medical needs, Medi-Cal will modify the request. If oxygen is used for less than 24 hours per day, Medi-Cal may pro-rate the reimbursement to reflect less than 24 hours per day utilization of oxygen. If there is medical necessity that justifies a recipient's use of a higher cost supplemental oxygen system, it must be documented in detail by the physician prescribing the system. If a higher cost system is requested only for the recipient's and/or provider's convenience, the TAR may be authorized but reimbursement will be at the rate of the lowest cost item.

E. If a patient qualifies for additional payment for greater than four LPM and also meets the requirements for portable oxygen (E0431 or E0434), payment will be made for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied.

F. Monthly rental and reimbursement for purchased oxygen concentrators (E1390, E1391 and E1392) include all accessories, delivery and set-up. A portable gaseous system may be added if there is a documented need for mobility or exercise.

*Please see* **Oxygen and Related Equipment**, *page 8*

G. After one year of oxygen therapy, re-certification is required for continued use. The request must include a recent ABG report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test, in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

*This information is reflected on manual replacement pages medi non hcp 3 (Part 2) and modif app 5 (Part 2).*

## Cancer Detection Programs Forms and Directory Available Only on the Web

The following Cancer Detection Program forms and *Regional Cancer Detection Partnership Contacts Directory* section have been removed from the hard copy and online manuals. The Cancer Detection forms are now available in electronic format only on the "Cancer Detection Programs: Every Woman Counts Downloads" page of the Medi-Cal Web site (**www.medi-cal.ca.gov**). To access the following three forms, click the "Cancer Detection" link on the Medi-Cal home page.

- *Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (English form)
- *Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (Spanish form)
- *Consent to Participate in Program* and *Notice of Privacy Practices* (English)

Information on the *Regional Cancer Detection Partnerships* is located on the Cancer Detection Programs: Every Woman Counts Web site (**www.dhs.ca.gov/cancerdetection/cancerpartnerships.htm**).

*This information is reflected on manual replacement pages can detect 2 and 9 thru 11 (Part 2).*

## California Children's Services Program Updates

Updates to the California Children's Services (CCS) Service Code Groupings (SCGs) are as follows:

| Code | SCGs updated | Effective for Dates of Service on or after: |
|---|---|---|
| Z5956 | 04 | July 1, 2004 |
| Z0306 | 01, 02, 03 and 07 | July 1, 2006 |
| C9225 | 01, 02, 03 and 07 | November 1, 2006 |
| J3490 | 01, 02, 03 and 07 | December 1, 2006 |
| J3590 | 01, 02, 03 and 07 | December 1, 2006 |

**Reminder:** SCG 02 includes all codes found in SCG 01, plus additional codes applicable only to SCG 02. SCG 03 contains all codes found in SCG 01 and 02, plus additional codes applicable only to SCG 03. SCG 07 contains all codes found in SCG 01, plus additional codes applicable only to SCG 07.

**New Medical Therapy SCG Added**
Effective retroactively for dates of service on or after November 1, 2006, a new SCG has been added. Medical Therapy (SCG 11) codes are used by physical and occupational therapists. The codes contained in this new SCG are not included in any other SCG, and SCG 11 does not include codes from any other SCGs.

*This information is reflected on manual replacement pages cal child ser 1, 3, 16 and 24 (Part 2).*

## Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

***Fresno***

**February 22, 2007**
**8:30 a.m. – 4:30 p.m.**

Piccadilly Inn – West Shaw Hotel
2305 West Shaw Avenue
Fresno, CA 93711
(559) 226-3850

***San Bernardino***

**April 12, 2007**
**8:30 a.m. – 4:30 p.m.**

Clarion Hotel & Convention Center
295 North E Street
San Bernardino, CA 92401
(909) 381-6181

For a map and directions to these locations, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the appropriate location. In the "Provider Orientation & Update Session" document, click the "For directions: click here" link.

**Registration**
To register for an orientation and update session, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the "Registration" link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

*Please see* **Family PACT**, *page 10*

**Check-In**
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

**Note:** Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

**Certificate of Attendance**
Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

**Contact Information**
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*

## Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

**Addition, effective May 26, 2006**

| Drug | Size and/or Strength |
|---|---|
| * THALIDOMIDE | |
| Capsules | 50 mg |
| | 100 mg |
| | 200 mg |

* Restricted to use in the treatment of Multiple Myeloma.

**Addition, effective June 29, 2006**

| Drug | Size and/or Strength |
|---|---|
| * LENALIDOMIDE | |
| Capsules | 5 mg |
| | 10 mg |
| | 15 mg |
| | 25 mg |

* Restricted to use in the treatment of Multiple Myeloma.

**Addition, effective October 6, 2006**

| Drug | Size and/or Strength |
|---|---|
| VORINOSTAT | |
| Capsules | 100 mg |

*Please see* **Contract Drugs**, *page 11*

**Addition, effective October 13, 2006**

| **Drug** | **Size and/or Strength** |
|---|---|
| PANITUMUMAB | |
| Injection | 20mg/cc |

**Change, effective October 23, 2006**

| **Drug** | **Size and/or Strength** |
|---|---|
| * ATAZANAVIR SULFATE | |
| Capsules | 100 mg |
| | 150 mg |
| | 200 mg |
| | **300 mg** |

* Restricted to use as combination therapy in the treatment of Human Immunodeficiency Virus (HIV) infection.

**Changes, effective December 1, 2006**

| **Drug** | **Size and/or Strength** |
|---|---|
| FLUTICASONE PROPIONATE AND SALMETROL | |
| Oral powder for inhalation | 100 mcg/50 mcg per inhalation |
| | 250 mcg/50 mcg per inhalation |
| | 500 mcg/50 mcg per inhalation |

**Note:** "ea" means one blister of drug.

**Oral Inhaler, without chlorofluorocarbons as the propellant**

| | | |
|---|---|---|
| | **45 mcg/21 mcg per inhalation** | **12 Gm** |
| | **115 mcg/21 mcg per inhalation** | **12 Gm** |
| | **230 mcg/21 mcg per inhalation** | **12 Gm** |

| | |
|---|---|
| RAMELTEON | |
| * Tablets | 8 mg |

* Restricted **to use in the treatment of insomnia and** to a maximum dispensing quantity of thirty (30) tablets and a maximum of three (3) dispensings in any seventy-five (75) day period.

*Please see* **Contract Drugs**, *page 12*

**Changes, effective February 1, 2007**

| **Drug** | **Size and/or Strength** | |
|---|---|---|
| * ALBUTEROL | | |
| Inhaler with adapter | 17 Gm | |
| Inhaler without adapter | 17 Gm | |
| * **Restricted to dates of service from January 1, 1996 to January 31, 2007.** | | |
| ALBUTEROL SULFATE | | |
| + Tablets or capsules | 2 mg | |
| | 4 mg | |
| + Long-acting tablets | 4 mg | |
| | 8 mg | |
| * Inhaler (without chlorofluorocarbons as the propellant) | 6.7 Gm | |
| * **Restricted to dates of service from October 1, 1996 to January 31, 2007.** | | |
| Solution for inhalation | 0.5 % | |
| Solution for inhalation | 0.083 % | |
| | 1.25 mg/3 cc | |
| | 0.63 mg/3 cc | |
| Liquid | 2 mg/5 cc | |
| Capsules for inhalation with inhalation device | Package containing 96 or 100 capsules and one inhalation device | |
| Capsules only, for inhalation | | |
| * METAPROTERENOL | | |
| Inhalant solution | 0.6 % | 2.5 cc |
| | 5 % | 10 cc |
| | | 30 cc |
| Aerosol inhaler with adapter | | 14 Gm |
| Aerosol inhaler without adapter (refill) | | 14 Gm |
| + Tablets | | 10 mg |
| | | 20 mg |
| Liquid | | 10 mg/5 cc |
| * **Restricted to dates of service from March 1, 1994 to January 31, 2007.** | | |
| PIRBUTEROL ACETATE | | |
| * Aerosol inhaler with adapter | 14 Gm | |
| | 25.6 Gm | |
| * **Restricted to dates of service from March 1, 1994 to January 31, 2007.** | | |

+ Frequency of billing requirement

# Instructions for Manual Replacement Pages — Part 2

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| | |
|---|---|
| Remove and replace: | *Contents for Obstetrics Billing and Policy* i/ii *<br>cal child ser 1 thru 4, 15/16 |
| Remove:<br>Insert: | cal child ser 23<br>cal child ser 23/24 |
| Remove and replace: | can detect 1/2, 9 thru 12 |
| Remove at the end of *Cancer Detection Programs: Every Woman Counts:* | *Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (English form)<br>*Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (Spanish form)<br>*Consent to Participate in Program* and *Notice of Privacy Practices* (English) |
| Remove section at the end of *Cancer Detection Programs: Every Woman Counts Billing Examples – HCFA 1500:* | *Cancer Detection Programs: Every Woman Counts Regional Detection Partnership Contacts Directory* |
| Remove and replace: | eval 7/8<br>fam planning 7/8<br>hcpcs ii 1/2<br>inject 1/2, 45 thru 58 * |
| Insert: | inject 59 |
| Remove and replace: | inject list 3 thru 6, 15 thru 18 *<br>inject vacc 1<br>medi non hcp 3<br>modif app 5/6<br>modif used 3/4, 7/8<br>non ph 11/12<br>path chem 3 thru 6<br>path organ 1/2<br>radi dia 19/20 |
| Remove:<br>Insert: | rates max lab 1 thru 8<br>rates max lab 1 |

* Pages updated due to ongoing provider manual revisions.